NEW JERSEY

Child Fatalities & Near Fatalities

Review Board Report

2021 Data and Recommendations

RECOMMENDATIONS

Key Takeaways

- The Board reviewed 135 cases involving fatalities or near fatalities that occurred in 2021, 10 percent fewer than 2020.
  - Nearly half (49 percent) of cases reviewed involved infants.
  - Males accounted for 59 percent of cases reviewed.
  - 36 percent of cases reviewed involved a Black child
  - Half of the children had family history of prior involvement with child protective services
- **Sudden unexpected infant death (SUID)**: The Board reviewed 49 SUID cases; this represents three-quarters of all cases involving infants. Most SUID cases (88%) involved an unsafe sleep characteristic, such as not sleeping in a crib or bassinet.
- **Suicide**: In 2021, 16 child suicides occurred, 8 fewer than in 2020. These cases most often involved older youth. In half of the cases, the youth had a mental health diagnosis.
- **Homicide**: The Board reviewed 21 homicide cases. Three-quarters of these cases involved a child under the age of five.
- **Accidental Drowning**: In 2021, 14 accidental drownings of children occurred. Most (9 of 14 cases) involved a child ages 1 to 4 years old. In ten cases, the Board's review determined the child lacked adequate supervision.

The death or serious injury of a child is a loss to everyone. New Jersey established the Child Fatality and Near Fatality Review Board on July 31, 1997, through the Comprehensive Child Abuse Prevention and Treatment Act. The Board reviews fatalities and near fatalities of children due to unusual circumstances and determines the cause, the relationship to governmental support systems, and methods for future prevention. The Board reviewed 135 cases that occurred in 2021 and made the following recommendations:

To improve timely determination of the cause of death and understand contributing factors

- The NJ Governor, Legislature, and Department of Health should allocate funding to the Medical Examiners' offices for blood screening systems that provide immediate toxicology results.
- The Medical Examiner should complete a comprehensive drug panel, for prescription and illicit drugs, during an autopsy on all adolescent cases.

To improve assessment of family's needs

- The Department of Children and Families (DCF) should contract an expert to develop guidance and protocols for suspected Munchausen by proxy for DCP&P staff, schools, and the medical community.
- DCF Division of Child Protection and Permanency (DCP&P) should require longer supervision timeframes and additional approvals to close cases involving high-risk substance abuse and young children.
- DCP&P should offer (require) ongoing training for caseworkers on identifying patterns of physical abuse, interview techniques including when children recant disclosures, and implicit bias.

To improve communication and coordination

- The Department of Health should implement a system to alert DCP&P and providers when an adult, who is a sole caregiver, experiences a psychiatric episode and is involuntarily committed so that efforts can be made to ensure a caregiver for the child.
- The Children's System of Care and DCP&P should develop practices to enhance coordination and communication to improve their ability to share information when they both serve a youth or family

To reduce accidental drownings

- The NJ Governor, Legislature, Department of Consumer Affairs and Department of Health should implement more public service announcements and other preventative initiatives focusing on pool safety and drowning prevention.
- The NJ Governor and Legislature should enact legislation requiring more state-level regulations and oversight of protective measures related to recreational swim safety. This will ensure consistency in safety protocols across the state.

To prevent and respond to overdoses

- The Department of Education should provide more education in the school systems on Samaritan Laws and signs of overdose.

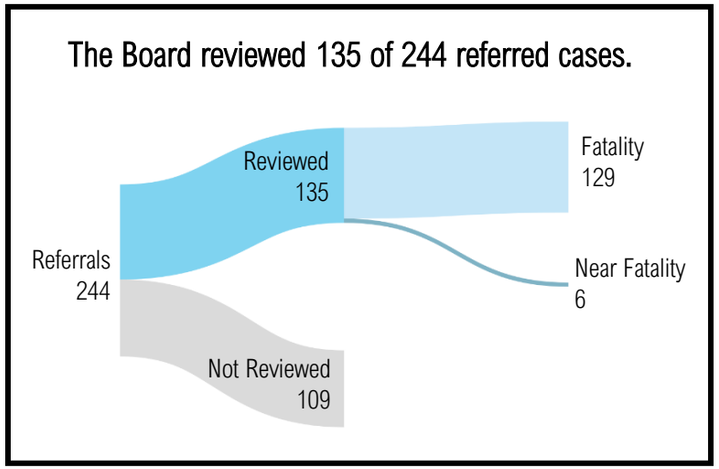
CHILD FATALITIES & NEAR FATALITIES OF UNUSUAL CIRCUMSTANCES

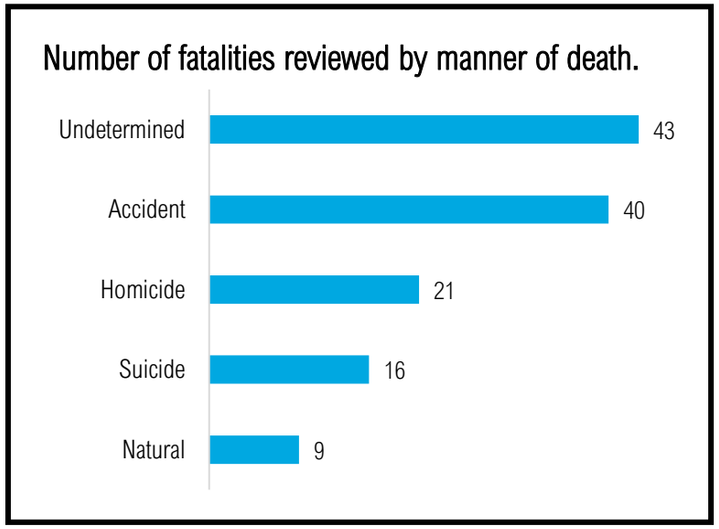
New Jersey's Child Fatality and Near Fatality Review Board receives notification about cases from several groups including the Child Abuse Hotline (the DCF State Central Registry), the Office of the Chief State Medical Examiner, law enforcement, and the Department of Health. The Board received 244 notifications in 2021.

The Comprehensive Child Abuse Prevention and Treatment Act (CAPTA) established criteria the Board used to determine 135 cases were eligible for review, 10 percent fewer cases than in 2020. For these cases, the Board obtained relevant records such as the autopsy, death scene investigation, law enforcement records, medical information, and social service records.

Near fatalities accounted for 4 percent of reviewed cases. For a near fatality to be eligible for review, a physician must certify the condition as serious or critical and the allegation of child abuse or child neglect must be substantiated.

Most cases reviewed by the Board were child fatalities. After an autopsy, the medical examiner's office determines the primary manner and cause of death. Most frequently the manner of death was undetermined, followed by accident.





Reasons the Board reviews a child fatality

Unclear Cause
- Undetermined cause of death
- Sudden unexpected infant death
- Burns without obvious reason such as a house fire
- Head trauma, fractures, or blunt force trauma without obvious reason such as a car accident

Abuse or Neglect
- Homicide resulting from child abuse or neglect
- Child experienced sexual abuse
- Suffocation or asphyxia
- Malnutrition, dehydration, medical neglect, or failure to thrive
- Child abuse or neglect may be a contributing factor

Substance Misuse
- Substance misuse may be a contributing factor
- Motor vehicle accidents in which the child or a caregiver driving had a positive toxicology screen

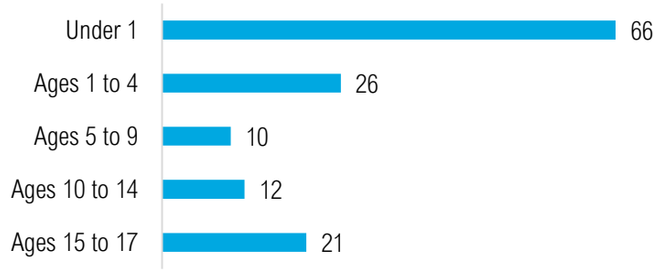
Self-Harm and Accidental Deaths
- Suicide
- Drowning

Child Welfare Involvement
- Children whose families were under DCP&P supervision at the time or within 12 months preceding the incident

CHARACTERISTICS OF CHILDREN

Nearly half of cases reviewed involved an infant.

Number of cases reviewed by age.



59%
of child fatalities and near fatalities involved **males**.

Cases reviewed overrepresent Black children compared to New Jersey's child population.

Percent of cases reviewed by race and ethnicity

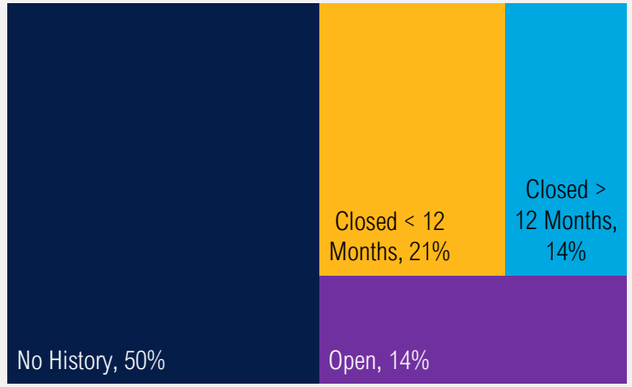
* Includes American Indian, Alaska Native, Native Hawaiian, Pacific Islander, and people who identify as multiracial.

Involvement with Child Protective Services

The Board reviews fatalities and near fatalities of unusual circumstances regardless of the child's involvement with child welfare. In reviewing these incidents, the Board aims to improve social services and to prevent future incidents from occurring. The Board examines the roles of many agencies and systems, recognizing that the Department of Children and Families (DCF) is an important provider of social services to families.

Half of the children had family history of prior involvement with DCP&P. At the time of the child's fatality or near fatality, 35 percent of families had a previously closed case with DCP&P and 14 percent of families had an open case.

Families had a history of involvement with child protection services in half of the cases reviewed.



How a Family Become Involved with Child Protective Services

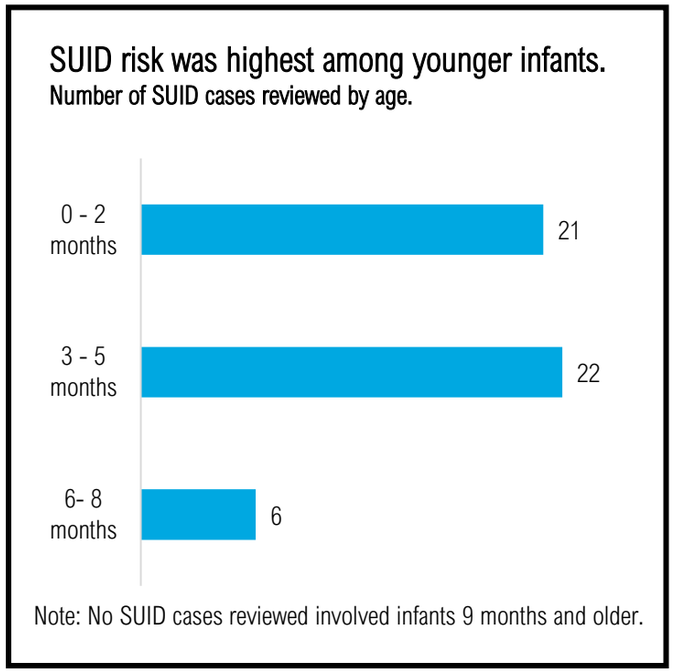
DCP&P investigates reports of child abuse and neglect that come in through the Child Abuse Hotline, which operates 24-hours a day, 7-days a week. If a report does not meet the criteria for an assessment or investigation, the caller is given information about services through community providers and a DCP&P case is not opened. For reports that meet the criteria, DCP&P local staff conduct an assessment or investigation to determine if neglect or abuse occurred. Once the assessment or investigation is completed, a decision is made whether to open a case for the family to receive services. Even if neglect and abuse were not found, a case may be open if other concerns are identified, or if the family may benefit from services. A family's involvement with DCP&P is voluntary unless the Court has approved care and supervision or the removal of a child from the home.

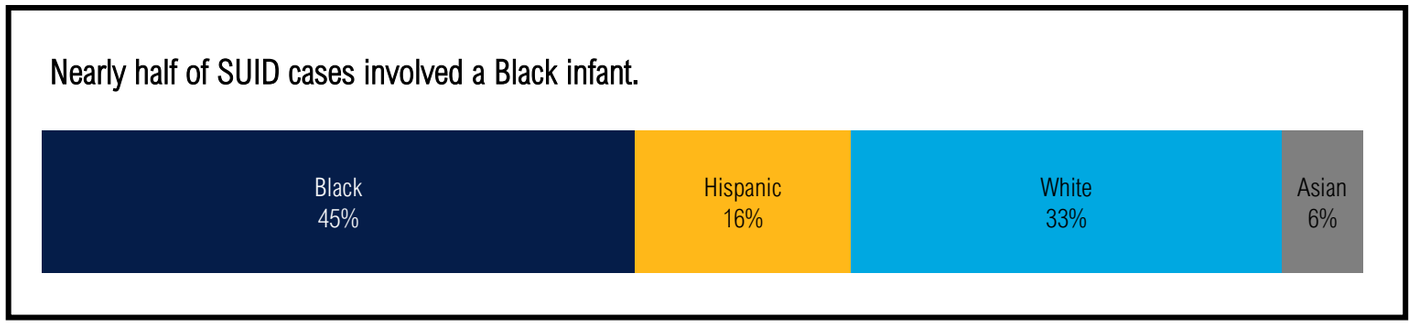
SUDDEN UNEXPECTED INFANT DEATH

The Centers for Disease Control and Prevention (CDC) defines Sudden Unexpected Infant Death (SUID) as the death of an infant under the age of 1 that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before an investigation. SUID includes instances of sudden infant death syndrome, accidental suffocation or strangulation in bed, and other deaths of unknown cause[2].

The Board reviewed 66 cases involving an infant under the age of 1; nearly three-quarters (74%) of these cases had SUID as the cause of death. Between 2020 and 2021, the number of SUID cases in New Jersey fell 29% from 69 to 49 cases. New Jersey had a SUID rate of 49 deaths per 100,000 live births, lower than the national rate of 99 in 2021[3-4].

The Board reviewed more SUID cases involving males (57%, 28 cases) than females (43%, 21 cases).





Preventing SUID - Safe Sleep Practices

To better understand the risks associated with SUID, New Jersey examines the characteristics and circumstances of SUID fatalities. The Board via DCF shares this data with the Centers for Disease Control and Prevention's SUID monitoring program.

Most SUID cases had an unsafe sleep characteristic.

- **88%** of infants were not sleeping in a crib or bassinet.
- **76%** of infants had a toy or loose bedding in the space while sleeping.
- **69%** of infants slept with another person.
- **59%** of infants were not sleeping on their back.

A safe sleep environment follows the ABCs of safe sleep[5]:

- **Alone**. Infants should sleep alone. Sleeping with people or pets can be unsafe.
- **Back**. Infants should be placed on their backs to sleep, for naps and at night.
- **Crib**. Infants should sleep in a firm, flat crib with no soft blankets or toys. Sleeping on couches is not safe for infants.

SUICIDE

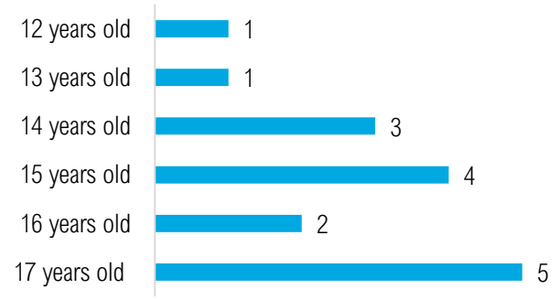
The Board reviews all suicide cases involving children under the age of 18. In 2021, the Board reviewed 16 suicide cases, 8 fewer than in 2020. New Jersey had a lower suicide rate among children ages 9 to 17 than the national rate, 1.5 compared to 4.6 suicides per 100,000 children[6].

The most common method of suicide used by children in New Jersey was asphyxiation (38%, 6 cases), including hanging, strangling, and suffocation. The second most prevalent method was blunt force trauma (31%, 5 cases). Less common methods include the use of firearms (19%, 3 cases) and drug overdoses (13%, 2 cases).

Most suicide cases (10 of 16 cases) involved males.

Suicide cases most often involved older youth.

Number of suicide cases reviewed by age



Most common factors surrounding child suicide.

A single event or circumstance rarely causes suicide.

- **50%** of youth (8 of 16) had a mental health diagnosis.
- **44%** of youth (7 of 16) had a history of self-harming behaviors.
- **38%** of youth (6 of 16) experienced a recent or serious loss.
- **31%** of youth (5 of 16) had access to lethal means.
- **31%** of youth (5 of 16) felt social isolation.

Suicide Prevention Resource for Families

2ND FLOOR

People ages 10 to 24 can confidentially and/or anonymously call or text **1-888-222-2228** to talk to someone about a problem or issue they are facing. An app is also available for download.

PerformCARE®

Call **1-877-652-2764** to receive treatment and referrals for children and youth, including emergency mobile response services.

988 SUICIDE & CRISIS LIFELINE

Anyone can call **988**, a 24/7 free confidential lifeline for themselves or someone they know.

HOMICIDE

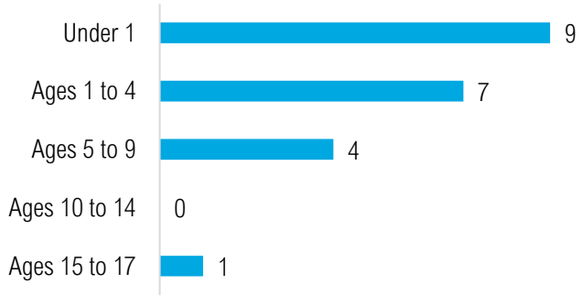
The Board reviewed more than twice as many cases of child homicides in 2021 than in 2020 - 21 cases compared to 8 cases.

The Board reviewed a similar number of homicide cases involving females (11 cases) and males (10 cases).

Homicides reviewed by the Board involve younger children, most frequently. Children under the age of 5 account for three-quarters of homicide cases reviewed.

Younger children were most frequently involved in homicide cases reviewed.

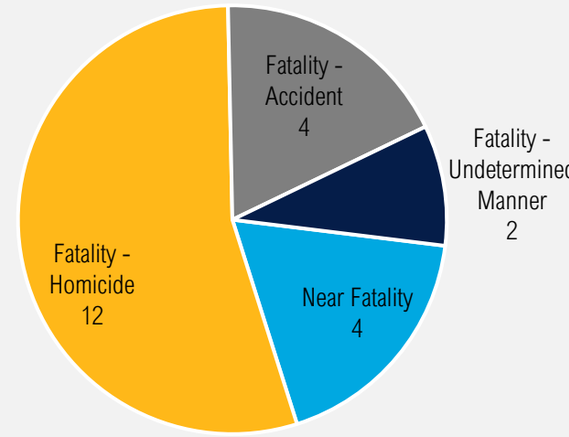
Number of homicide cases reviewed by age



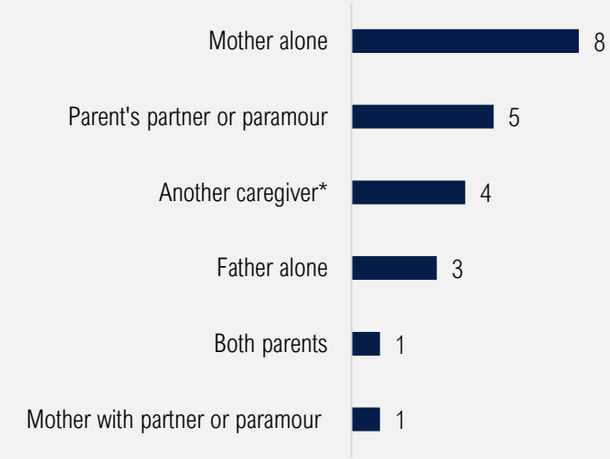
Perpetrators of Child Abuse or Neglect Fatalities and Near Fatalities

The Comprehensive Child Abuse Prevention and Treatment Act allows DCP&P to release certain information regarding child fatalities and near fatalities resulting from abuse or neglect. Of the cases reviewed by the Board, 22 were investigated by DCP&P and determined to be a result of child abuse or neglect. Four cases were near fatalities and the remaining 18 were fatalities. Slightly more than half of these cases were homicides (12 cases). As part of the investigation, DCP&P identifies an alleged perpetrator and their relationship to the child. The investigation found that at least one parent was responsible in over half of the cases (13 cases).

Half of cases investigated and determined to be a result of abuse and neglect were homicides.



Identified Perpetrator's Relationship to Child



** Includes babysitter, family friend, relative, and resource parent.*

ACCIDENTAL DROWNINGS

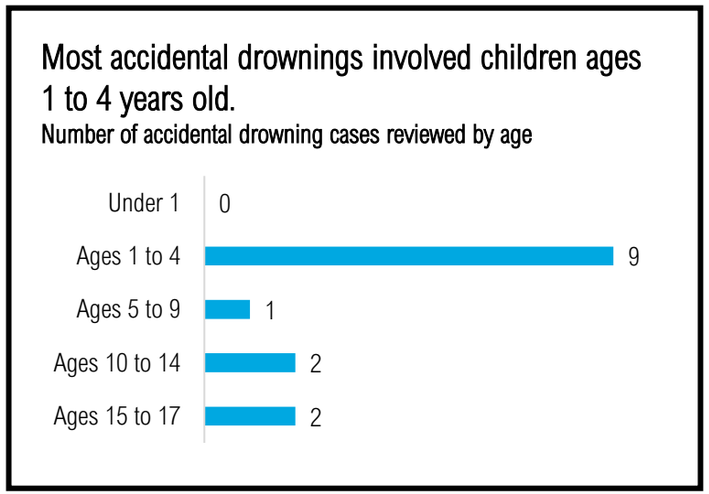
The Board reviewed 40 accidental deaths in 2021; of which, 35 percent (14 cases) were accidental drownings. There was no change in the number of accidental drowning fatalities reviewed from 2020 to 2021.

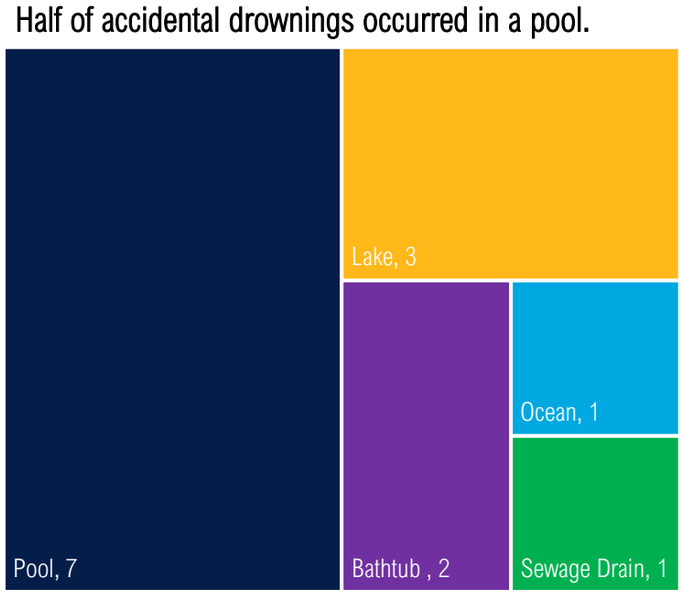
Most accidental drownings reviewed involved children ages 1 to 4 years old. Nationally the most frequent cause of death for this age group is drowning[7]. Half of the accidental drownings reviewed occurred in a pool. Accidental drownings reviewed involved a similar number of females (6 cases) and males (8 cases).

Adopting water safety practices may prevent similar accidents. In ten cases, the child lacked adequate supervision. In five cases, the pool was unsecure or lacked fencing.

Water Safety Practices for Caregivers[7-8]

- Never leave a child unattended near water.
- Empty inflatable pools, buckets, pails, and bathtubs after each use.
- Stay within an arm's length of small children in water.
- Fully enclose pools with a fence.
- Remove all pool toys that may attract children.
- Never swim without a lifeguard.
- Wear a life jacket instead of relying on air-filled or foam toys.
- Help children understand the difference between pools and natural bodies of water.
- Teach children about water safety and how to swim at an early age.
- Learn CPR.





References

1. U.S. Census Bureau, Population Division (2024, June) *State Population Estimates. Annual State Resident Population Estimates for 6 Race Groups by Age, Sex, and Hispanic Origin: April 1, 2020 to July 1, 2024.* https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-detail.html
2. Centers for Disease Control and Prevention (n.d.). *Sudden unexpected infant death and sudden infant death syndrome.* https://www.cdc.gov/sudden-infant-death/about/index.html
3. New Jersey Department of Health. (n.d.). *Birth query module: Count of live births in 2021*. https://www-doh.nj.gov/doh-shad/query/result/birth/BirthBirthCnty/Count.html
4. Centers for Disease Control and Prevention. (n.d.). *Sudden unexpected infant death and sudden infant death syndrome: Data and statistics*. https://www.cdc.gov/sudden-infant-death/data-research/data/sids-deaths-by-cause.html
5. Nationwide Children's Hospital. (2014, September). *The ABCs of safe sleep* https://www.nationwidechildrens.org/family-resources-education/700childrens/2014/09/the-abcs-of-safe-sleep
6. Centers for Disease Control and Prevention (n.d.). *CDC WONDER: Underlying Cause of Death 2018 – 2023*. https://wonder.cdc.gov/
7. Centers for Disease Control and Prevention. (2024, October). *Preventing Drowning*. https://www.cdc.gov/drowning/prevention/index.html
8. New Jersey Department of Children and Families (n.d.) *Child Safety Campaigns. Not Even a Second – Never Leave a Child Unattended Around Water*. https://www.nj.gov/dcf/families/safety/water/

APPENDIX 1. THE BOARD MEMBERS

The Board reviews fatalities and near fatalities as a team that includes representatives from law enforcement, child protective services, prosecutors and district attorneys, medical examiners and coroners, pediatricians, and other health providers. The composition of the Board aligns with best practice recommendations from the National Center for Fatality and Review Prevention. The Board contains six teams: State Child Fatality and Near Fatality Review Board, Northern Community-Based Team, Central Community-Based Team, Southern Community-Based Team, Suicide Subcommittee, and Sudden Unexpected Infant Death Subcommittee. The Board is in, but not of, the Department of Children and Families, but it operates independently without control or supervision from the Department. Professional staff from the Department of Children and Families act as liaisons that carry out the duties of the Board, including issuing this annual report. Below is the list of Board Members and Department of Children and Families liaisons as of July 2025.

Department of Children and Families Liaisons to the Board

Tamika Young, MSW
Program Manager, Fatality Review
Tamika.Young@dcf.nj.gov

Lauren Woods
Supervisor, Fatality Review
Lauren.Woods@dcf.nj.gov

Elizabeth Peña
Liaison, Fatality Review
Elizabeth.Pena@dcf.nj.gov

Michelle Floyd
Liaison, Fatality Review
Michelle.Floyd@dcf.nj.gov

Jazmyn Montalvo
Liaison, Fatality Review
Jazmyn.Montalvo@dcf.nj.gov

State Child Fatality and Near Fatality Review Board Members

Dr. Laura Brennan, M.D., Chair
Pediatrics
Center for Children Support School for Osteopathic Medicine

Elayne Weitz, Psy.D., Co-Chair
Psychologist

Kathleen Lyons-Boswick, Esq. BSN, RN (ret)
Supervising Assistant Prosecutor
Essex County Prosecutor's Office

Lea DeGuilo,
Assistant Section Chief
DCF North of the Division of Law

Bethany D'Amelio
Executive Coordinator
New Jersey Task Force on Child abuse and Neglect
Department of Children and Families

Robyne Jiles, MSW
Assistant Director of DCP&P Central Operations
Department of Children and Families

Brian Ross
Assistant Commissioner for Legal and Regulatory Affairs
Department of Children and Families

Alex X. Zhang, M.D.
Acting Chief State Medical Examiner
Office of the State Medical Examiner

Adam Brozek
Detective Sergeant First Class
New Jersey State Police
Major Crime North Unit

Jennifer Pax, Ph.D., JD, MSW, LCSW
New Jersey City University

Nichole Lane
Deputy Public Defender
Office of Law Guardian

Nancy Scotto-Rosato
Department of Health and Senior Services

Northern Community Based Team

Jennifer Romalin, RN, MSN, APN, Chair
Hackensack University Medical Center - AHCH

Christopher Schellhorn
Chief Assistant Prosecutor (Tactical Division)
Morris County Prosecutor's Office

Jeffrey Conrad
Prosecutor
Morris County Prosecutor's Office

Javier M. Toro
Captain of Detectives, Special Victims Unit
Office of the Hudson County Prosecutor

Wendy Crossan Ricci, Esq.
Staff Attorney, Office of the Law Guardian
Asst. Deputy Public Defender

Sandra Parente
County Service Specialist
DCP&P, Department of Children and Families
Bergen and Hudson Area Office

Karen Eigen, MD, MPH
Attending Physician, Pediatric Emergency Dept.
Hackensack Medical Center
Assistant Professor, Hackensack Meridian School of Medicine

Di Wang, MD, PhD. MA
American Board-certified Pathologist and board-certified Forensic Pathologist
Morris Tri-County Medical Examiner

Central Community-Based Team Members

Gladibel Medina, M.D., CAP, Chair
Medical Director
Dorothy B Hersh Child Protection Center

Dr. Francesco Pontoriero, DO
Pediatric Forensic Pathologist
Assistant Medical Examiner
Middlesex Regional Medical Examiner's Office

Laura Badilla, MSW
CP&P, Department of Children and Families
HMSW Area Office

Laura Johnson, Ph.D., MSW
Temple University

Patricia Soffer, Esq
Assistant Deputy Public Defender – Law Guardian Attorney
Office of the Law Guardian

Kari A. Mastro, PhD, RN, NEA-BC, FAAN
Director of Practice, Innovation and Research at Penn Medicine
Faculty at the University of Pennsylvania
Penn Medicine Princeton Health

Porsha Moody
Program Manager/State Coordinator
Child Passenger Safety and Safe Kids New Jersey

Southern Community-Based Team Members

Dr. Laura Brennan, Chair
Pediatrics
Center for Children Support School of Osteopathic Medicine

Ian Hood, M.D., ChB., JD
Medical Examiner
Burlington County

Kristin Nanette Briggs, Esq.
Assistant Deputy Public Defender
Office of the Law Guardian
Southeast Region

Jacqueline Forss
Case Practice Liaison
CP&P, Department of Children and Families
Cumberland, Gloucester, and Salem Area

Jill Ditalia-Clark
Casework Supervisor
DCP&P, Department of Children and Families
Camden North

Frank Sabella, M.S.
Detective Sergeant
Cumberland County Prosecutor's Office

John H. Flammer, Esq.
Chief Counsel to the Prosecutor
Atlantic County Prosecutor's Office

Sergeant Chad Meyers
Atlantic County Prosecutor's Office
Special Victims Unit

Suicide Subcommittee Members

Dr. Andrew Falzon, MD
State Medical Examiner
Office of the State Medical Examiner

Mary F Beirne, MS, EdD, M.D., DFAPA
Dept of Children and Families, Rutgers

Melinda P. Carnassale, Deputy Director
Children's System of Care
Department of Children and Families

Jennie Blakney, M.A., Ed
Child and Adolescent Health Program Manager
New Jersey Department of Health

Michelle Scott, Ph.D., M.S.W.
Professor, School of Social Work
Director, SRF Suicide Prevention Research and Training Project
Monmouth University

Suzy Azevedo
Principal
Edgar Middle School

Maureen A. Brogan, LPC, ACS, DAAETS
Program Director
Rutgers Health, Traumatic Loss Coalition

Iris Moore
Camden North Local Office Manager
CP&P, Department of Children and Families

Marisol Garces, MSW, LSW
Local Office Manager
CP&P, Department of Children and Families

Susan M. L. Paredes
Teacher, School Administrator
Metuchen Public Schools

Sudden Unexpected Infant Death Subcommittee Members

Lenore Scott, LWS
Assistant Division Director
Office of Early Childhood Services
Department of Children and Families

Susan Fiorilla, MSW, LCSW
Supervising Family Service Specialist I
CP&P Department of Children and Families
Burlington West Local Office

Alissa K. Sandler, MSW, LCSW
Manager, Pediatric Social Work
Hackensack Meridian Children's Health at Joseph M. Sanzari Children's Hospital

Nichole Lane
Deputy Public Defender
Office of the Law Guardian

Frederick J. DiCarlo, M.D., Ph.D.
Deputy Medical Examiner
Morris Tri-County Medical Examiner's Office

Kimberly DeNick, M.D.
Advocare Pediatrics

Matthew Maguire
EMS Medical Director Coordinator
Cooper University Health Care

Genevieve Lalanne-Raymond,
Lead Maternal and Child Health Epidemiologist
NJ Department of Health

Katie Magee-Lee
Prosecutor
Middlesex County Prosecutor's Office

Report Authors:
Victoria Perez-Zetune, Lauren Woods, and Tamika Young

For additional information, contact:
Tamika Young
Program Manager, Office of Quality
New Jersey Department of Children and Families
Tamika.Young@dcf.nj.gov